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DATE NOTICE SENT TO ALL PARTIES: Apr/20/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: TENS unit for purchase - right wrist

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for a purchase of a TENS unit for the right wrist is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: This patient is reported to be a male who was taken to surgery on 03/11/10 for a closed displaced right distal radius fracture and the procedure performed at that time was an open reduction and internal fixation of the right distal radius fracture. On 02/17/15, he was seen in clinic with complaints of hand pain. On exam right wrist extensors and flexors were rated at 4/5 and sensation was intact. He had pain rated at 5/10 to the right wrist. Actively, the patient could extend the wrist to 40 degrees and flex to 50 degrees. He had 20 degrees of active radial and ulnar deviation. A TENS unit was recommended. It was noted he had a TENS unit in the past which had helped his pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 02/23/15, a utilization review report was submitted for the requested purchase of a TENS unit, it was noted the request was non-certified. It was noted that there is no documentation that the patient had undergone a 30 day trial that had shown benefit or that the patient was actively enrolled in a program with a functional restoration approach to use in conjunction with the TENS unit. Therefore the request was non-certified. On 03/20/15, the utilization review for the same request on appeal, stated the request was non-certified, as there was a lack of documentation that the patient had undergone a 30 day trial. In addition, the use of a TENS unit for the wrist was not recommended by the guidelines. On 04/02/15, a carrier submission noted that the request for a TENS unit purchase, was not medically necessary and not supported by the documentation provided. The Official Disability Guidelines forearm, wrist, and hand chapter, indicate that TENS units are not recommended as there is a lack of scientifically proven efficacy in the treatment of acute hand, wrist, or forearm symptoms and there is conflicting evidence of the effect of a TENS unit on pain outcomes in patients with arthritis in the hand. The records do not indicate that the patient has tried a 1 month trial of a TENS unit, and there is a lack of documentation of the overall efficacy if one has been tried but just not reported. Therefore, it is the opinion of this reviewer that the request for a purchase of a TENS unit for the right wrist is not medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)